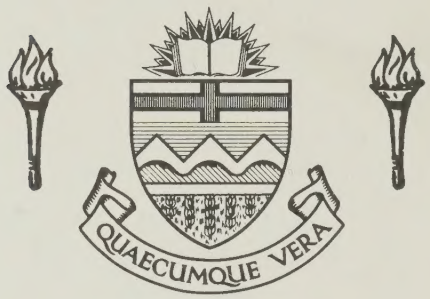

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EDUCATION IN HEALTH CARE IN AN INTERCULTURAL MATERNITY SERVICE

by

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A THESIS

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ABSTRACT

Health care provided by the modern medical establishment includes education of clients, concommitant with the change--disease, trauma or condition--which dictates treatment. Expertise in providing such education is based upon education of the health care worker in both medical and extra-medical domains of knowledge, definitive of a knowledge-oriented work community.

This study is an exploration of several educational aspects of the health care of maternity patients in a Canadian hospital which serves a population of both native and non-native clients. Interviews with health care workers document a difference between natives and non-natives perceived by those health care workers. The specific differences are categorized and data, gathered through participant-observation in the hospital, is compared to the health-care workers' perceptions, using several variables in ante-, peri- and postnatal care and education.

It was found that differences exist, both in native and non-native response to the treatment surrounding maternity health care, and in the workers' interactions with clients, based on the workers' apparent definitions

of a native/non-native distinction. The findings reflect a need for a better definition of such differences, where they in fact exist, and for subsequent improvement in the education of health-care workers.

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CHAPTER I

INTRODUCTION

This thesis is an exploratory study which attempts to address a problem of practical importance. The modern health care establishment deals with a fairly specialized and scientifically-rationalized body of knowledge. This epistemological base forms a rationale for specific activities for specific "treatment" of members of society. The goal of this "treatment" is change--individual or societal change. A great deal of the activity that surrounds the treatment is manifestly educative.

In this thesis a specific complex of health care workers and their clientele are examined in a fairly specific area of health care, that of childbirth.

The practical problems are immense. A Western Canadian hospital whose clientele unitl recently has been nearly uniformly native, has provided a service defined as complete maternity care. As the hospital began to serve an other-than-native population as well, and as natives became free to choose alternatives to this hospital, a differential in patient learning needs has been both (1) tacitly accounted for; and (2) ignored.

This thesis is an attempt to document (1) staff perception of differentially-defined sub-groups, that is, native and non-native; (2) institutional accomodation to that difference; (3) documentation and/or testing of specifically defined differences; and (4) implications for institutional change in the definition of educational needs, both of the professional staff and of the clientele.

Thus the study is a descriptive one, and descriptive on several broad axes. It is exploratory, and thus is severely limited by methodological considerations, primarily restrictions in access to data.

The theoretical problems are no less troublesome. A given theoretical statement is appealed to, in this study, insofar as it appears to be more nearly adequately descriptive of a social situation than some alternative theoretical statement. Thus no theoretical problem is enunciated or explicated in the thesis: the nature of the practical problem demands an initial, exploratory study. The purpose of this thesis is to accomplish that end.

In this introduction, two concepts will be enunciated. The first is a broad definition of <u>education</u>, whereby the content of education, as opposed to the personnel involved, is its definitive characteristic. Then that content, insofar as it is defined situationally by health care workers, is claimed to be contextually

subject to varying interpretive matrices: the term "reality construct" as explained by Holzner (1968) is put forward as a term that might describe the justification for the codification of what is defined as educationally appropriate by the medical establishment.

The two terms, "education" and "reality construct", introduce a short discussion of the modern concepts of health care education, relative to childbirth, as perceived by the medical establishment.

Definitions

Education.--As Cohen (1971) addresses the mechanisms by which societies perpetuate the symbols that individuals in a society learn--and thus, for many anthropologists--ensure the self-perpetuation of the society, he finds it useful to distinguish between "socialization" and "education". "Education," he says, "is the inculcation of standardized and stereotyped knowledge, skills, values, and attitudes by means of standardized and stereotyped procedures," (1971:22). "Socialization" as he defines it, does not occur "at regular times, in predictable ways, and at set places"; it is not thus stereotyped and standardized. He maintains that "education" takes place in the most primitive cultures, but speculates that

> the quantitative role played by socialization in the development of the individual is in direct proportion to the extent to which the network of kin relations coincides with the network of

> personal relations. Correlatively, education tends to increase proportionately with the degree to which the network of kin relations fails to coincide with the network of personal relations.

He develops the distinction further, generally by defining the "who" and "what" of "education". In so doing he can come to the conclusion that "the essence of education--vis-a-vis socialization--is that one of its principal emphases is on universalistic values, criteria, and standards of performance," (1971:39), and further, that

> An increasing reliance on education is adaptive to a rapid rate of change and to a high valuation of change because it contributes to the development of habit of mind by which the individual evaluates an item of information in terms of its utility instead of the particular individuals or settings in association with whom it was learned. It not only contributes to an amenability to new knowledge, but also to new social responses to changing conditions. Education, especially when it predominates over socialization, contributes to the establishment of a particular attitude toward change (1971:46).

Thus, for Cohen, societal self-perpetuation through educational institutions, along with the rituals and processes they incorporate, includes the mechanism for societal and cultural change.

This thesis is not a test of Cohen's dynamics, but rather embraces his definition of "education" and the context in which it takes place; as working definitions: as a foundation upon which to discuss more or less standardized, routinized, stereotyped and ritualized behaviour in a health-care setting, where the content, the medically-defined "knowledge" requisites for normative

societal functioning are ostensibly taught.

Many aspects of modern health care are manifestly educative in Cohen's terms. A problem arises, however, in differential definitions between members of the health care professions, e.g., professional nursing staffs, and their clients, in the definition of what "knowledge" must be transmitted. The frames of reference in which clients and professionals approach the educative rituals may vary. The problems of differential perceptions of "what is going on" and "what should go on" in health-care education are compounded when the professional corps deals with a culturally-different clientele.

Reality construct.--Along with Holzner (1968) the term "reality construct" will be employed in this thesis to refer to the complexes of frames of reference by which groups of individuals interpret "objective fact". Holzner says, in defense of the term,

> It may appear to some unnecessarily cumbersome. We wish to defend it on the grounds that we need the term. It indicates that we are not concerned with the study of ideal conditions for the discovery of truly "objective facts" as such. This means that we do not search for normative grounds on which to defend the superiority of any particular perspective such as that of science. Instead, we study descriptively the conditions under which social agents of different kinds consider any information as representing a "fact" (1968:14-15).

The development of that construct, or its exposition, is not the purpose of this thesis, but it is a construct with which we must deal in order to avoid the

simple explanations of "cultural relativity" and the concommitant problems of dealing with "cultural knowledge" along with all the speculation about cultural determinism and cognitive processes that these terms might imply. It is with acknowledgement of Holzner's dictum that we approach the description of a social setting in which education is perceived as a component of health care:

> We will never forget that the construction of reality occurs in a social context; we must transcend the phenomonology of it until we reach a sociology of reality construction. Only then can we hope to understand the wide divergence of modes of reality construction, which can lead different persons to make sometimes entirely different assertions about the "same" state of affairs (1968:15).

Of particular importance in this respect is Holzner's discussion of the social organization of specialized knowledge, under which rubric he discusses the "knowledge oriented work community."

> Such groups provide special orientations, regulate in large measure the flow of work situations, and maintain rather elaborate controls of communication. Thus, they become major forces in the social constructions and elaborations of reality. Where knowledge itself becomes the focus, rather than the mere tool of work, we are dealing with knowledge oriented work communities (1968:127).

When he discusses the relations of the knowledge oriented work community to its social setting, he states that, capitalizing on its work function, the work community uses "power strategies" to create "simplified and stylized representations of behavior patterns, which may correspond only loosely with the overt activities of the worker"

to create a role image. It is the role image "which allows the various publics with whom the member of the work community interacts to place him into a meaningful context" (1968:128).

Of crucial importance to the discussion of a specific knowledge oriented work community, which is the concern of this thesis, the health-care establishment and specifically the nursing profession, is Holzner's elaboration of this concept of role image.

> It stabilizes the often highly fluid and diverse relations which the member of the work community must have with his publics, and it organizes the reactions of members of other groups to him. He is likely at least to try to influence this image, especially at those points at which it is "put to a test," or in the actual work performance before others who are not members of the work community and in the general flow of communication which forms "public opinion" and enters into the determination of "common sense." Even the most highly specialized worker must in the course of his work performance contact laymen. He may, it is true, work for and with persons whose specializations differ but slightly from his own, so that there are degrees of being a layman. Nevertheless, at some point in the process of production or in the exercise of his skill and provision of his service, he must give knowledge and make decisions which concern persons who cannot share his specialized mode of reality construction. These points of contact are one important link between his knowledge specialization and the domain of common sense. It is at this point that a very significant evaluation of the outcome of his work takes place: it may be acceptable or unacceptable to the public (1968:128-129).

The Professional Rationale For Patient Education

General rationale.--Health care teaching in modern nursing is part of nursing care. The aim of health care teaching is directed toward groups when a general topic needs to be disseminated. But health care teaching has the greatest value for the individual who has a specific condition or problem which requires control, management or life-style adjustment. The teaching may be directed to the understanding of a temporary condition, and how to cope with it, or it may be much more intense, aiming to change existing behaviour of an individual.

Health care teaching covers the whole range of human conditions and miseries. Much of the teaching is informal and pertains to transitory conditions such as corrective and emergency surgery, and bacterial and viral invasion. But often, as the result of surgery and physiological changes, the life-styles of individuals have to be changed, as in diabetes mellitus, the amputation of a limb, or with childbirth. In such cases, a role change may be required to accomodate for the result of trauma, disease, or changed status.

Patient teaching is the response to a need directed toward a mental, physical or social reality, however defined. This form of teaching is a complex and rewarding side of nursing, with learners often

acutely aware of their normal and abnormal body functions. A great number of people experience some difficulties in describing or translating their perception of their own body functions into a practical reality. Nursing education has to combine disease process and treatment as well as the social and cultural background of the individual if success and change is to be assured. Health is not only the desire of an individual, but society, as well, has cultural norms which indicate what health should be. These popular health indicators point toward a maximum degree of fitness and youthfulness in appearance, and perfection of body image, which is often at variance with reality.

The specific rationale for antenatal instruction in classes.--In antenatal and postnatal teaching, the opinions of health teachers are that through simple, intelligent discussion and instruction, expectant mothers are prepared for the change which is taking place. That is, it is hoped that they have a greater preparedness and know more of what to expect during pregnancy, delivery and infant care. It is hoped that through this teaching fact and fiction will be sifted from each other. And it is believed that this will aid the individual parent, especially the mother, in her new role and give her better tools: confidence and information. Also, it is thought that in antenatal classes an expectant mother has an

opportunity to ask questions and can have concerns clarified in the course of formal and informal teaching. This is thought to contribute to a reduction in stress. In addition, the association of a pregnant woman with other expectant mothers may lead to an exchange of ideas, while complaints and concerns can be aired among peers. And often during this antenatal period a mother may perceive a specific condition of herself and/or the infant as being pathological--erroneously: hence, teaching can reduce or avoid anxiety.

The expectant mother usually hears alternative approaches to various aspects of maternal and child care, and with access to this information may have the chance to make her own decisions in childbirth and infant care, in those areas where the profession sees choice as possible and not precluded by physiological considerations.

It is thought that the presence of the father in the antenatal class, and possibly in the delivery room, adds to his understanding of the process of childbirth, and through this the family bonds may become stronger and more durable.

Patient-Professional interaction in health care education.--Interaction must be examined as cultural, group and individual activities that are influenced by age, education, geography and individual perception and personality.

For Goffman (1967) action and interaction between men reflect a degree of uniformity and sameness: these are the shared biological aspects that, almost without exception, are an innate, unavoidable prescription that man accepts as part of being man. The second form of action and interaction are ritualistic gestures that are practiced by participants. Interactions between people proceed according to a code that reflects the status, role and rights and obligations that each of those categories manifest. The actors in the interplay vary their behaviour according to the role they have assumed at the time of a particular interaction. Hence, interpretations of behaviour may be many-faceted, depending upon the nature of the situation in which a person finds himself, and upon what he assumes the demands, in the form of responses, to be. Goffman believes that man wants to save face, so will attempt to avoid issues that present him in an unfavourable light, and that he will do this by manoeuvers of avoidance, compliance, silence, and, if necessary, misbehaviour. And in an intercultural setting these strategies are all evident, with the less dominant group often displaying two forms of interaction. One form of behaviour is an attempt to meet the expectations of the dominant group, while the second form of behaviour is the in-group activities that display the ethnic character of the minority. By this latter

kind of action, anxieties and tensions are resolved, and the integrity of the minority is less threatened.

In health care, dominance is vested in the health care worker by virtue of specific skills, skills that are needed and cannot readily be rejected without grave consequences to the individual patient. Power is therefore inherent in the skill, and the exercise of that power is not unlike political power which can grant a relative degree of freedom through meaningful action and interaction. In health care, the main object is to allow the patient, whenever possible, the working through of a negative or positive diagnosis, and the participation of the patient in his own care in a way that comes closest to his regular mode of living.

The assumptions in patient teaching and in the interaction between health care personnel and the patient are that (a) the patient seeks advice from health care personnel because of the superior skill such personnel possess in analysing and interpreting health needs; (b) the majority of patients are interested in their own health. The care provided in health centres and from doctors' offices is sounder, and therefore more desirable, than prevailing opinions or the practice of folk medicine; and (c) interaction between health care workers and patients can be on an equal footing, provided health care workers recognize that potential in a patient, and

allow patients to express their own needs. This last assumption dictates that professionals avoid the overt manifestation of "professional" behaviour, which might reflect the differences between patient and workers in terms of language and attitude.

CHAPTER II

SOME HISTORICAL AND ALTERNATIVE VIEWS CONCERNING CHILDBIRTH

A Brief Historical Review

The history of femininity, pregnancy and childbirth of the native population has been recorded by non-natives who made early culture contact with the tribes of North America. Later documentation was by anthropological investigators in the interest of social science. But in both instances we are provided with accounts by persons from outside the native cultures. This may account for the fact that many aspects of native life were written about in terms of generalization and appear to cut across tribal and cultural areas.

Modern obstetrical care is an outgrowth of scientific medicine, which developed with progress through time, and it reflects the professional opinion of health personnel to which patients are subjected. Native mothers have, like members of most other cultures, retained some of the "folk" concepts about childbearing,

but generally they have accepted the superimposed obstetrical care of this age, perhaps with reservations by some. The original native concepts of childbearing are no longer dominant.

Historically childbirth in native and other cultures was an event looked upon nowadays as being complexes of superstitions and taboos (some of which are still with us) with hardly any physiological and anatomical understanding, and without medication for the relief of labour pain. In Western cultures the concept of childbearing can be traced through many dominant ethnic groups in history. The Books of Moses state that after the fall of Adam and Eve, God condemned Eve to have her children in pain. This is the theme that seems to run through Western attitude toward childbirth, and which has influenced obstetrical care through several centuries. Femininity and childbirth in native cultures had no diety which condemned women, but there were certainly complexes of other beliefs.

For example, menarche meant that a new part of the life cycle had begun, which could not be explained in terms of physiology; but the changed status of the girl was certainly understood. The reality of these attitudes toward females is well documented by Ackerknecht (1946) who made the following observations.

> It is a well known fact that all over the world the sexual and reproductive functions of women are heavily tabooed because of their mysterious,

> awesome, and disgust- or fear-inspiring character. It is not improbable that this primitive attitude toward the female sex function is instrumental in the discrimination against women in cults, and various other activities in primitive societies, all the more as such discrimination usually ceases when women have passed the menopause and become sexually neutral. Of almost universal distribution and surviving in a rational form in this society are the taboos against menstruating women. Less common, but still very widespread are the taboos against pregnant women, women in childbirth (1946:145).

With the colonization of the North American continent by European powers, England, in particular, left its puritanical mark. European traditions, superstitions and speculation gave more room for widespread taboos in childbirth. Britain and Continental Europe, in certain areas, differed in religion but, in taboos and superstitions they showed a remarkable likeness.

Midwives were sometimes thought to be witches, who delighted Satan by offering him the infants which they had killed. Thus it was logical that priests often were instrumental in choosing a midwife, not on the basis of medical knowledge, but only if "she be free of all suspicions of heresy, witchcraft, superstitions, or any other crime whatsoever and finally that she be of exemplary life and morals (Forbes 1962:278)."

Doctors and midwives were subject to emotional reactions by their clients, and the midwife frequently "was accused of practicing the black arts, often unjustly, but sometimes, it appears, quite correctly (Forbes 1962:280)." The texts for midwives therefore

were not instructions of how to practice the art of safe care and delivery, but rather about how to avoid getting drawn into the spiritual sickness of that time. The instructions actually were a threat to her, and read, in one case,

> No midwife shall secretly pass on or sell to questionable persons for misuse and perpetration of most damnable wickedness the so-called string or naval cord, afterbirth, Helmlein and Kleidlein (caul) which the baby brings into the world; if this occurs, she will be severly punished (Forbes 1962:267).

(By contrast, several native cultures prescribed that the cord be dried and used as a protective medicine for the infant.)

American historians document the fact that advances in medicine in Europe were not always implemented in North America because many of the theories, especially germ theory, were not accepted on this continent for some time. This probably occured because earlier in the 18th Century

> medicine was cluttered with a variety of theories arising from speculations as to the cause and mechanism of disease and its therapy which were based upon arbitrary hypotheses founded upon scientifically determined facts (Coste 1952:10).

To add further to the complexity on the North American continent there was the fact that

> of the approximately five hundred physicians estimated as practicing in Virginia at the end of the eighteenth century only about fifty-five held degrees. The greater number had received training through apprenticeships. While

> many of these men were very well trained, possessed natural ability, and proved to be excellent physicians, the opportunity was there for lax standards and much unskilled practice (Coste 1952:11).

Hard work, frugality and piety were the key words to success for the dominant Anglo-Saxon group in North America. That often meant suppression and re-channeling of personal feelings and circumventing a physical, sexual reality at the expense of psychological trauma.

It is at this point where American natives differed from the dominant "other" culture. Most natives had a greater openness in terms of sexual functions: women learned their biological sexual role and accepted it as feminine, while the individual non-native female experienced fear, because she lacked the solid preparedness of her native sisters. The white woman was taught the puritanical cant of sinful femininity that started early in life but "in the pubertal period many receive the first blow; ere the girl is fully aware of the change which has taken place, or is warned by a mother of its coming and significance," (Engelman 1900:759).

The lack of preparedness could be seen in the dominant society, because women were not prepared for the great fluctuations of physical and emotional stress during puberty, childbearing periods and the menopause. And that neglect did not seem to be found in the native population:

> We hear of the vigor of the savage woman, of her capacity for work, her ability to follow the warrior on the march, and why is this? It is because she is judiciously cared for during every period of functional life and this care is given to women by primitive peoples of every race, of every color, in every clime. It is the teaching of the intuition, the instinct of self-preservation which recognizes the importance of the function, lest only among the very lowest tribes in whom the attributes of women begin to disappear and even the frame approximates that of the male. These were the teachings of the great lawgivers--Moses and Zoroaster--and where religious law did not command, custom, equally potent, prevailed, enforcing rest and abstinence from labour and the daily work routine. So essential did rest seem, and what is more, rest in the recumbent position, that among some peoples we find the hut for the menstruating woman so low that the upright position was impossible, she was obliged to lie down (Engelman 1900:791).

At one point it seems that the feminine role indeed became submerged in puritan convention, and its identity fused, and woman became a necessary being for procreation and sexual fulfillment, but without acknowledging this biological reality as a necessary expression of living. Hence, in the dominant Anglo-Saxon group, femininity and childbirth in the 19th Century showed "to a great extent a misdirected refinement of civilization, ignorance of and disregard of the function, the crushing out of every question of sex in the girl, who soon learns to ignore, conceal, and deceive (Engelman 1900:791)."

With increasing culture contact a peculiar situation arose and native women increasingly sought and were

encouraged to have hospital confinement in surroundings whose sterility went deeper than germ theory, and isolated mother and child from the father and the rest of the family: something which seemed to have been more readily acceptable in the non-native group. Native people at the time of culture contact and for some time later practiced medicine which combined the sum total of man's behaviour: his physical and psychological well-being; isolation of the different components was an unknown categorization. "The shaman played the most significant role in traditional medicine, although his unique powers were not confined to medicine alone, but were often used in relgious or social setting (Miles 1967:429)."

Childbirth for most native tribes of North America was an anticipatory female function, necessary for a full life experience. And for most tribal women "birth is a personal matter and thus cannot possibly be of interest to anyone else (Loughlin 1965:55)." As she addresses Navajo women, Loughlin continues "It is the ultimate goal of the women to bear children and it is never considered an illness to be endured for nine months. There are many taboos and rituals to be observed during the pregnancy, not only by the prospective parents, but by the entire family" (1965:55). Some taboos often were sound and supportive of good health, as defined by modern medicine, and the "expectant mother was warned not to eat much food

at any time, since it would make the baby large and labour difficult, and she was to observe this rule, especially, immediately prior to the birth process" (Hildebrand 1970:35). This very excellent teaching, now practiced in health care centres, was complemented by many superstitions, some having a parallel in the Europeans' past and present taboos. The looking at deformed persons, or being frightened by nasty animals, or desiring certain food, are common taboos. Hildebrand (1970:35) says that, of native women, "the child's head would be large and his limbs feeble if a pregnant woman ate either the head or the tail of any vertebrate animal."

But upon closer examination of the earliest recorded culture patterns of the native population, the pregnant woman is seen to have received an adequate diet and

> there was no loss of vitamins in the foods eaten by the Indian, because they consumed all edible plants. Minerals and vitamins were obtained through vegetables, grains, berries, fruits and nuts. Fish and fish oils supplied them with vitamin D, while carbohydrates were furnished by turnips, potatoes, parsnips, wild rice, maise and various berries. Maple sap and honey provided sugar. All slaughtered animals were eaten in their entirety, including the bones, and this was an excellent source of protein and fats" (Hildebrand 1970:36).

The actual delivery of the infant was an all-woman affair, although in some tribes such as the Chippewa the "medicine man visited her and offered her a

slippery elm bark tea" (Hildebrand 1970:36). This tea apparently speeded up labour, which took place in small shelters that were built for the mother to give birth in. But if the birth occurred during a journey, babies were delivered in the open country. The mother was assisted by midwives and the cord was cut by one of the attendants --or the mother herself--as most native women gave birth in a squatting position. Medications were given in the form of ointments and tea for a variety of conditions such as excessive uterine bleeding or engorged breasts. But no medications were given for the pain. Hildebrand (1970:37) says that "it was thought that the pain made the baby come."

Infant feeding was entirely by breast. In some specific cases "caesarian section was also performed on rare occasions if the birth of an heir to the tribe took priority over the life of the mother" (Fiddes 1965: 401).

In the 20th Century the native group in particular was asked to accept more and more of the other culture's medical and obstetrical care, particularly since there was a breakdown in traditional native medicine. The art of modern medicine is sophisticated, but even so, sections of the non-native group, in many instances on the North American continent have not made use of the recommended obstetrical services. Ferguson (1950:85) notes that

> In 1947 midwives attended 23,815 (36 per cent) of the women who bore children in Mississippi. Before the present state supervision was established, the midwife practiced as she pleased. She conducted deliveries as she had seen her neighbors and older midwives conduct them. She was often physically and mentally unfit to perform the function.

And in Canada the desire to have all women deliver in hospital is not yet the desire of all patients. Though the extreme majority are, nowadays, it was only as far back as 1948 that it was estimated that 47 per cent of pregnant women were delivered in hospital (Kerr 1948:399).

A notable group of people in Western Canada are at a remote native campsite. Here, by choice and with material support from the Department of National Health and Welfare, most women, except for primiparous women, are delivered at the campsite by native midwives.

The Counter Culture

In the dominant culture a new element has entered that has radically challenged obstetrical care: the counter cultures of Canada and the United States. These sub-cultures often reject accepted conventions, including standard medical care. The young people of this counter culture have been raised, for the most part, "by members of prosperous middle-class families where parents diagnose ailments and then select specialists to cure them, or medicate family members with over-the-counter drugs" (Brodnax 1973:16).

Though they may seek to imitate the native culture in some respects, the counter culture members are often less supportive of the pregnant woman than the old tribal culture of the native population. In the counter culture "folk traditions are being revived and rather selectively combined without regard for either origin or the locale in which they were used" (Fleshman 1973:96).

The counter culture prescribes how a pregnant woman should behave, although the "culture takes on aspects of various other cultures, chiefly Eastern, and changes much more rapidly than other cultures. It is also a highly individualized culture in that each person can take any aspect of the culture for his own and reject any with which he does not feel comfortable" (Bancroft 1973:68).

The rejection of certain health care aspects by the counter culture does not mean refusal of all care by all parties, however. The care taken and sought is usually provided in public health or free clinics which are manned by health care professionals free-of-charge to the patient, or by medicare. It is this culture which is much more insistent on the father of the baby being present during delivery, and he may play a major role. "If the staff ignore the father," Bancroft (1973:71) says, "he feels unwanted; the couple feel that the clinic has bad 'vibes'."

For health care workers to ensure that members of the counter culture make use of hospitals, health care workers and hospitals have to make large concessions. Mothers often refuse sedation of any form, demand that both father and mother handle the child at once after birth, and put it to the breast immediately. Also, the conventional North American strapping down of the patient for delivery in the prone position is rejected, and their belief is that

> we must control our own lives by ourselves. One magazine advertized in undergound papers describes its contents as demystifying professionalism and showing how people can control their own lives when relating to professionals and medical situations (Bancroft 1973:73).

Edwards (1973) reports of sub-culture groups who refuse hospitalization, where women are delivered in the commune in which they live. They are ambulatory during a longer period of labour than are hospital patients, may take tea, or alcohol or marijuana in small amounts as tranquilizers, and insist on the father's presence. Edwards notes that "exclusion of the father has given way to exclusion of the physician. A doctor friend may stand by but he intervenes only when the father asks him to" (1973:1334-1335).[1]

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[1]Members of Canadian communes seem less vehement in the rejection of hospital services. The experience of this writer is that fathers insist upon attending the birth and prevent the administration of medication to the mother, as "unnatural". Attendance at antenatal classes by "counter culture" members seems to be unusual in Canada.

It seems that in the United States home deliveries, where the doctor and the nurse are excluded, are on the increase. Edwards (1973) says that as early as 1971 home birth--many of them unattended by health care workers--was the choice of 25 per cent of all couples taking antenatal classes at the Los Angeles Institute of Family Relations and estimates that in the San Francisco Bay Area there are 100 unattended home births each month (1973:1332).

Thus the natives at the remote camp have a counterpart in the "deviant" offspring of middle-class white culture. Both groups challenge the so-called "rational" approach in teaching and obstetrics in the conventional care of patients as perceived by health care workers.

CHAPTER III

THE HOSPITAL AND ITS SERVICES

The Hospital Setting

The urban hospital used in this study is the nexus from which client education regarding childbirth takes place. The patient load in admissions to maternity is comprised of registered Indians, Inuit, Metis and "others." All but the latter, according to the policy of the hospital, have priority admission rights over other ethnic groups. (This priority, however, is extended to "others" from the Yukon and Northwest Territories.) The "others" group consists of both Canadian-born, and European and other immigrants. The native population is diverse, coming generally from a 30 to 40 mile radius around the urban centre in which the hospital is located, but including a variety of tribal and linguistic affiliates. A number of urban natives use the hospital facilities. Notwithstanding the variety of native people in the hospital, the predominant language, other than English, is Cree.

During the year 1973, there were 457 maternity patients admitted. Of this group, 157, or about 34%,

were native. In 1974, of the 508 maternity patients admitted, around 40%, or 208, were natives. During 1975 (up until August), of the 470 patients admitted to the maternity unit, only 100, or about 21%, were native.

This declining figure may represent the new choices available to registered Indians in the selection of health care facilities. During the period in which this study was completed, several doctors in general or specialized practice admitted maternity patients to the hospital. Practically uniformly, these private patients were classified as "other." Most native patients take advantage of out-patient clinics at the hospital, and a small minority of patients--particularly those classified as Eskimo--are from remote areas and have not had access to the urban hospital for prenatal care.

The maternity unit.--The maternity unit in this hospital is a self-sufficient unit with a bed capacity of 26, and that includes antenatal, labour rooms and postnatal beds. The nursery is in the centre and is easily accessible from the delivery room and the postnatal area. That is, mothers can observe their infants throught a 24-hour period. The patient rooms have four, two or one bed and are assigned according to needs: no preference is given according to "private" or "native" status. The labour rooms have two beds each. All rooms are equipped with ordinary call bells and an emergency call system. Suction

and oxygen equipment is available in specific patient post-partum areas, all labour rooms and the nursery. The maternity unit has no other patient unit nearby, and thus conforms to the constraint that maternity patients should be protected from other potential infection hazards.

The nursing staff.--The supervisor and the head nurse hold diplomas in midwifery in addition to the conventional nursing training. The general duty nurses have additional obstetrical training as well, and five of them are midwives. The total number of registered nurses is 16, covering all shifts. The unit has an active in-service program for on-the-job training for new graduates. Also, the nursing unit in charged with patient teaching, including a few antenatal patients. Most of the patient teaching pertains to postnatal patients and infant care. The actual patient teaching is done by registered nurses, and senior registered nurses present classes to prenatal groups. The teaching responsibility by certified nursing assistants is negligible and incidental.

The medical staff.--The obstetrical unit is headed by the Chief of Obstetrics and Gynecology, two additional specialists and general practitioners. Obstetrical medical residents and medical students rotate through the unit, each for the specified period of time required by the medical curriculum.

The physiotherapist.--The contribution of the physiotherapist is the teaching of the various levels of breathing, exercise and associated back massage. The two items are taught to the expectant mother and the latter to the father (in prenatal classes). Exercises are taught to all patients in the post-natal period.

The therapeutic dietician.--The main emphasis the dietician makes is to explain a combination of balanced food necessary for pregnant women during the prenatal classes. The dietician will work out specific food requirements which may be necessary if a patient has a physical condition which requires specific food intakes.

The Hospital Services

The Implicit Descriptive Schema

The three aspects of care, ante-, peri- and postnatal, will be discussed as to the specificity of personnel the hospital employs.

In order to form a descriptive grid for such an accounting, this section focuses upon specific components of the service orientations.

(1) Locus of service provided may range from out-patient care in the hospital complex itself; visits to physicians' offices; visits by public health nurses to reserves or remote camps; formal classes in the hospital, with or without designation of the client as "patient;"

home visits by public health nurses or social workers in the urban area; or actual in-patient teaching.

(2) Personnel whose function is to participate in the stereotyped, routinized educational process range in the hierarchy from (a) physicians; (b) residents; (c) registered nurses; (d) public health nurses; (e) para-professionals; (f) physiotherapists; and (g) dieticians.

(3) The content and (4) method employed in the (5) interaction ritual that defines the educational process are very often predictable, given (1) and (2) above. For example, a physician with a "private" patient, performs physical examinations and answers patients' questions in his office. Residents may perform equivalent functions at the out-patient clinic, and the physiotherapist may demonstrate, for example, back massage, in a prenatal class held in the hospital. Public health nurses visit reserves for both ante- and postnatal care, and, in the case of the remote camp, may assist at delivery.

A sixth category, always implicit in this discussion, is the assumption or denial of cultural difference.

The six descriptive categories are axes upon which the three aspects of natal care may be described.

Antenatal Educational Services

The primary focus in antenatal instruction is on the antenatal classes which have been held for the past four years in the hospital auditorium, with the

final class on the unit itself. Prior to the first class, key centres of communication were contacted and requested to provide information to potential clients. The agencies contacted included (1) the city public health service; (2) the provincial and Northern Region of National Health and Welfare; (3) all the physicians with admitting priveleges to the hospital; and (4) the out-patient department of the hospital itself.

The classes were first scheduled to coincide with the obstetrical day clinic held at the out-patient department, in the hope that prospective native mothers would more readily be able to attend the classes. However, native mothers did not take the opportunity, and other participants found that their husbands could not attend during working hours. Classes were shifted to the evening. Each course runs for seven weeks.

The curriculum includes the use of aids, such as slides, a doll which illustrates the position of the fetus in the pelvis, and a film showing prenatal exercises. There is a film shown of an actual delivery. Potential troubles are explained. The topics covered include (1) anatomy; (2) diet; (3) discomforts of pregnancy due to changes in physiology and posture; (4) labour and delivery; (5) infant care.

Other areas of antenatal instruction are in the out-patient clinics, the visits by public health nurses

outside the urban area, the private patients' conferences with their doctors during regular visits and examinations, and some antenatal instruction to in-patients who have not delivered. The variety of antenatal services available is shown in Table 1, on page 34.

Perinatal Educational Services

The second focus of patient teaching is at the time of admission to hospital, either in labour or for the treatment of prenatal complications. At this time a survey, in the form of a nursing history is taken (see Appendix A). This nursing history is intended to give an overview of the clinical picture, the patient's social and psychological needs, and indicates whether or not she has attended the prenatal classes. The information indicates to health workers whether or not patients have any theoretical exposure to the process of childbirth, and, if not, the nurse in particular is faced with a decision as to what area the patient needs most help with, or where the most support is needed.

A concommitant focus of patient teaching is in the post-partum period. The teaching is divided into two parts. (1) Self-care includes breast and perineal care and the instruction in exercises. (2) The second part of teaching in the post-partum period is that of infant care and feeding. Every day a registered nurse demonstrates such procedures as bathing the baby, and cord and

Table 1.--Summary of Antenatal Educational Services Offered.

Personnel	Locus	Content	Method	Cultural Difference Accounted For
physician	private clinic	explanation of physical examination response to patient's questions	dyadic relationship	service available generally; used primarily by non-native group
resident	out-patient clinic	same as above	same as above	service available generally; used primarily by native group; ward clerk speaks Cree
nurse-instructor; physio-therapist; dietician	ante-natal class in hospital	as in Chapter III	lecture; demonstration; classroom participant structures	set up primarily for native clients; used by two urban native couples only, and several non-natives
public health nurses	homes on reserves; remote camp	may perform some of physicians' role	dyad; small group	entirely native

circumcision care. After initial instruction, the mothers give the daily bath to their children under the supervision of the nurses.

A synopsis of perinatal educational services is shown on Table 2, on page 36.

Post-Confinement Education

These services normally include public health nurse instruction, a six-weeks check-up by the physician; child immunization, and possible visits by other social service workers. The services are shown schematically on Table 3, on page 37.

Table 2.--Summary of Perinatal Educational Services Offered.

Personnel	Locus	Content	Method	Cultural Difference Accounted For
physicians, residents	in-patient ward, hospital	instruction re delivery	dyad	most "other" patients are private patients; many native women attended by learners
nursing staff	as above	personal and infant care	dyad and small groups; classes	more nearly complete explanations perceived as necessary for native patients; more questions omitted from "other" patients' admissions forms.
dietician; physiotherapist	as above	as per specializations	classrooms; occasionally dyads	may perceive differential in "knowledge" needs
public health nurses	in-patient ward; regional hospitals	Purport to act as intermediaries for native patients		
	remote camp	birth procedures	dyads; small groups	only natives

Personnel	Locus	Service Provided	Cultural Difference Accounted For
Medical staff as defined in text	out-patient clinic; private clinics	six-week check-up for both mother and infant	Many less native women at six-week check-up; most non-native women at private clinics
public health nurses	homes on reserves; remote camp	equivalent services to six-week check-up	different organizational structure provided for home visits. Home visits for non-natives provided under different departmental aegis

Table 3.--Post-confinement or Postnatal Educational Services Offered.

CHAPTER IV

THE ANALYSIS OF PATIENT EDUCATION

Methodology

The thesis is elaborated from the perspective of a participant-observer. The investigator has been employed in various nursing capacities in the hospital for eight years. The focus of observation was primarily upon the medical and support staffs in order to find evidence for a collective body of knowledge upon which educational needs of clients was predicated.

Though of course there are differences of opinion among medical personnel as to what constitutes appropriate practice, given specific situations; what constitutes "science" in other words; another realm of knowledge must be dealt with. It is in no way peripheral to the "scientific" knowledge that the practitioners hold, but, as Holzner (1968) points out, constitutes that area where scientific knowledge is tested by laymen--where science must have some appeal to common sense.

A number of interviews were conducted by the researcher and are recorded in Appendix B. Of the 16 nurses on the ward, four declined to be interviewed. One native nurse was interviewed, as well.

Three public health nurses were interviewed: two have a primary responsibility on reserves near the city, as well as at a remote camp, and a third public health nurse works over an area approximately 150 miles from the city.

The chief physiotherapist at the hospital and the nursing supervisor of the out-patient department were interviewed as well.

It may be assumed that the interviews document staff perception of things as they are, and, in some cases, things as they should be.

Two other methods of data collection were used to compare with that documentation. The first was a sample that included very limited information from current records: race; decision as to adoption, if applicable; whether or not the mother intended to breastfeed; whether or not an episiotomy had been performed; the sex of the child; gravida of the client; other children at home; whether or not the child was circumcised, if it were male; and whether or not the father was in the delivery room.

These variables are all areas (except for the sex of the child) where nurses had documented differences between natives and non-natives. The sample completely exhausted the population of interest for all of August, September and October of 1974: all births on the unit were recorded.

A second sample, this one taken from the admission form (see Appendix A) documented these same variables, as well as many others, but access was only had to (1) the first five births of each month; (2) for each category, native and non-native. Thus there was no possibility of selecting a random sample. However, the records covered a 12-month period between November 1973, and October 1974.

Despite the inability to generalize, given the bias in the sampling procedures, that bias seems to be of sufficient independence of the variables under consideration for use in a pilot study such as the present one.

In most cases, simply descriptive statistics are shown in this study, and serve well to document the situation, particularly in the first three-month survey. In other cases, as warranted, a chi-square value is given in order to demonstrate association of specific variables.

Results of Interviews

Introduction

The interviews were all conducted separately, and include responses from (1) 12 registered nurses of non-native origin; and one registered nurse, a Cree-speaking native; (2) the supervisor of the out-patient department; (3) three public health nurses, whose responsibilities are defined by geographic area as being on reserves or at a remote camp; and (4) the chief physiotherapist.

All interviews were conducted in the hospital, during breaks in working hours, except for two (one public health nurse and one staff nurse) which were conducted at home. The questions were uniform, but were posed as components of conversation.

The object of the interviews was to elicit the staff's perception of native learning needs in the ante-, peri- and postnatal period, and to discern if there would be a native/non-native differential in that implicit definition of learning needs.

The interview questions and responses are shown in Appendix B.

Antenatal Education

The out-patient nursing supervisor.--It was the supervisor's opinion that the out-patient antenatal care differed between populations in that the native mothers made more use of the out-patient department, while non-native mothers were private patients and received antenatal instruction in private clinics. The sequence of visits, however, was seen to be the same ("Once a month, and, late in pregnancy, every two weeks"). The supervisor documented that one attending physician sees his patients regularly, while the other two normally delegate that service to residents.

She saw the changing clientele of the hospital in this way: the hospital had been an "Indian" hospital,

and was selected by many patients because of their familiarity with it. A "newer class" of native patients, "independent," "working," "able to choose without prompting," may have gone elsewhere. A new emphasis in the hospital, which allowed residents and learners new access to patients, made the hospital a less "personal" place, not allowing for the "one-to-one" relationship: many patients ask for specific doctors when requesting appointments.

The nursing staff.--There was general agreement among the staff that the freedom of choice afforded by the Federal-Provincial health care scheme presaged the decline in native maternity patients. A majority of the nurses used the term "more verbal" with respect to "modern natives," and four of the nurses used the term "intelligent" and "more independent" as applied to native patients nowadays, to reflect the reason for the declining native clientele.

The native nurse simply cited "convenience" as the reason why some natives still choose the hospital, while the other nurses felt that it represented a "social meeting place for their own people," as well as a convenience. A minority added that familiarity with the staff was a reason native women choose the hospital.

The one formal service for antenatal instruction was subscribed to by an extreme minority of native

patients. Half the nurses cited time conflicts, and 75 per cent of the nurses cited that the native women perceived no need for such classes. The native nurse added that "perhaps when they are more at ease, comfortable and secure" the native clients will make use of the antenatal classes.

There was considerable difference between the nurses when queried as to what native women know about pregnancy, delivery and postnatal care. Non-native respondents cited cultural knowledge factors as a reason for what they perceived to be comfortable acceptance of one's condition, and noted that the urban native women know as much as the non-native women about these functions.

The native respondent contradicted the opinion concerning cultural knowledge, but referred to attitude: anatomy and physiology might not be understood, but passive acceptance of both (1) one's condition; and (2) hospital procedures; were ascribed to feelings of inferiority in that social setting.

Only one of the non-native respondents considered native patients generally to be "deficient" in knowledge, most of them professing never to have met even one native patient who required specific antenatal instruction in preparation for delivery.[2]

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[2]That one nurse added that even though the very young patient may not "know," they "do very well."

The native respondent expressed no such confidence, and noted that native patients concealed their fright by acting passive.

The chief physiotherapist.--This individual has seen so few native patients in antenatal classes, her responses must be dealt with in the following section.

The public health nurses.--These nurses documented the change from the past practice of going to the urban hospital for delivery, and have facilitated access to regional and district hospitals, where they profess to act in an intermediary role. Two of the nurses act as "colleagues" of native midwives in the remote camp, where all but primiparous women are delivered at home.

They stress uniformly that what teaching they accomplish is (1) on a one-to-one basis in the home: they eschew the classroom or meeting situation; (2) they modify traditional scientifically-oriented curriculum to accomodate to individual lifestyle; (3) they foresee no future untilization of classes on reserves; and (4) that visits to the doctor are very important, even though the patient may not need to understand the scientific base from which the doctor operates.

Summary.--There is evidence that on all axes, health care personnel account for a perceived native/non-native difference in educational needs and responses to them.

Perinatal Education

Discussion.--The non-native nurses were uniform in their praise for native women in labour, though one noted that the occasional native woman "becomes hysterical." The native nurse attributed this perception to cultural attitudes: the native women simply tolerate labour.

Most of the nurses assume that native women accept episiotomy, knowing its scientific justification, but some agree with the native nurse that it is accepted simply because it is something the doctor does.

The consensus among all the nurses was that native women do not normally breastfeed their babies, and the public health nurses substantiate this claim, except for the remote camp. The native nurse documented the lack of breastfeeding as an item of real concern among Indian people: they enunciate a number of reasons for its demise and concommitant social repercussions.

Circumcision was seen by all the staff as being something simply not a part of the culture. The nurses were all concerned that the procedure be explained very carefully, as positive responses were received when the simple question was put forward to a patient, and "positive rejection" when it was explained. The "unusual case," where a native child is circumcised, was unaccounted for except for the minority of nurses (including the native nurse) who thought that perhaps "it is the association

with a man who is circumcised and who wishes the same for the baby." The public health nurses are casual, assuming a negative response to the suggestion, based on cultural norms.

Half the nurses said that "they have their own way of handling the babies" after delivery, referring to native mothers. All of the nurses agreed that "being used to children" accounted for the confidence which native mothers exhibited.

Terms of address vary. The native nurse, the out-patient supervisor and two of the public health nurses expect the mutual use of Christian names. One of the public health nurses consistently uses "Mrs." except for very young mothers; most of the nursing staff use "Mrs." except to unmarried women, who, they say, correct them. Several nurses report being called simply "nurse." Native males who visit the unit or the out-patient department are apparently never addressed by Christian names unless they are personal friends of the addressor.

The hospital nurses, as well as the out-patient supervisor, agree uniformly that one doctor delivers all his patients if possible; a second may attend, but supervises the delivery, which is attended by a resident or student; and a third doctor allows most of his patients to be delivered by the learners. The native nurse adds, "Native women, more so than others, can expect to be

delivered by learners; at least that seems to be the case judging by observation."

Though not revealed in the interviews, it is generally assumed that native mothers require fewer episiotomies.

Summary.--Native/non-native differences are implicitly ascribed in the areas of (1) breastfeeding; (2) circumcision; (3) behaviour during delivery; (3) expectations as to whether or not they will be delivered by an attending physician; and (4) the understanding of the physiology and anatomy of childbirth.

Postnatal Education

The physiotherapist reports that native women do "the exercises" in the hospital, but does not speculate on whether or not they do them after discharge. She evidences no such reluctance with respect to non-native patients, assuming that they do.

The out-patient supervisor reports that "many patients do not come back" after discharge for regular postnatal care. She cites transportation problems, the fact that many mothers work, and the fact that pediatric and obstetric check-ups are not coincidental, as reasons for failure to take advantage of this service.

Because most of the native patients are not "private" patients, it may be assumed that they do not

avail themselves of the services elsewhere. It is assumed that non-native patients have pediatric and obstetric examinations at private clinics.

General Summary

Questions in the interviews were posed in such a way that respondents were asked to objectify the native client. A definite stereotype results, and there is implicit or explicit comparison to non-native clients.

It was generally held that, though health care practices are based on specific scientific knowledge, that knowledge was not an educational need of native patients, who were, nevertheless, stereotypically "good" patients.

The questions are then posed: in the areas of ante-, peri- and postnatal care, how is the perceived difference accounted for; and, particularly in perinatal care, is there a differential in treatment?

The Survey Results

The survey data from which the following findings come were drawn from two sources. An initial three-month survey (August through October, 1974) was taken through observation in the hospital. During that time, 145 women delivered, live, 145 babies. (There was one stillbirth and one set of twins.) The variables observed were (1) race; whether or not (2) episiotomies; and (3) circumcisions were performed; (4) election of breast- or bottle feeding; and (5) the sex of the child. These data revealed little in the areas of ante- and postnatal care, but showed some differences, based on race, in response to perinatal treatment. (The data are summarized in Tables 4 through 18, incorporated under appropriate headings.)

The second source of data was a survey of admission documents. At the time of admission to hospital, a nursing history is completed for each patient. A copy of that form is shown in Appendix A. A number of responses are elicited from patients and some of the question responses on the form are documentary of the questioning nurses's assessment.

The admissions records of the first five births of each month, November 1973, through October 1974, were reviewed, in each racial category, "native" and "other." This constrained access to data precluded randomization of the sample: this is a serious drawback if one wishes to generalize results to indicate population parameters--

"population" in this context meaning the total population served by the hospital, and not the general population of the urban centre in which the hospital is located. There are, of course, a number of factors selecting for admission to this hospital, rather than to other area hospitals.

This inability to randomize the sample, however, does not vitiate the results of a pilot, investigatory study, except as some unaccounted-for variable might affect the time of the month of delivery.

Except where noted otherwise, the following data are from the nursing history form, taken at the time of admission. Percentages noted in the tables, in all cases, are for row totals, not columns.

Antenatal Education

Antenatal classes.--One of the questions asked of the patient is whether or not she has attended antenatal classes. Table 4 documents that attendance from the 12-month sample. While 30 per cent of the non-native mothers had attended classes prior to admission, only 3 per cent of the native mothers had taken advantage of them. The selection factor that may be at work is that such classes are a nominal prerequisite for a father's presence in the delivery room, and at the time of the study the hospital studied had been allowing this for longer than any other hospital in

	Did Attend	Did Not Attend	Total
Native	2 (3%)	58 (97%)	60
Non-native	18 (30%)	42 (70%)	60
Total	20 (17%)	100 (83%)	N=120

Table 4.--Attendance at pre-natal classes

the urban area. While less than a third of the non-native population took advantage of the classes, the table documents a real native/non-native difference in the kind of antenatal instruction a parent receives. The physiotherapist and dietician have no access to non-attending patients (refer to Table 1, page 34).

Public health nurse visits.--It is not known how many of the native mothers were visited by public health nurses during pregnancy, nor how many came from remote locations, but the number is estimated to be quite few.

Doctors' visits.--Even those native mothers visited by the public health nurses are encouraged to go to a doctor during pregnancy, and the out-patient nursing supervisor has maintained that visits under that aegis were the same as in a private clinic. Yet Table 5 shows a marked native/

non-native difference in documenting the last (if any) visit to a doctor by an admitted maternity patient. While just over two thirds of the native patients had visited a doctor during the last two weeks before admission, the comparable figure for non-natives is 96 per cent. There is an obvious difference in all categories, including the "not noted" category.

	Within Last 2 Weeks	Within Last Month	Within Last Tri-mester	Sometime Before Last Tri-mester	Never
Native	36 (68%)	6 (11%)	0	2 (4%)	9 (17%)
	Total native observations: 53*				
Non-native	58 (96%)	1 (2%)	1 (2%)	0	0
	Total non-native observations: 60				
Total	94 (83%)	7 (6%)	1 (1%)	2 (2%)	9 (8%)
	Total Observations: 113				

*Not noted on natives' documents: 7

Table 5.--Visits to Doctor During Pregnancy

Perinatal Education

This section may be divided into three general sub-sections. One demonstrates a presumed autonomous response on the part of the patient (for example, whether or not, in the opinion of the attendant, an episiotomy is required). Another class of questions tends to focus upon responses in which the mother makes a choice as to the care of the baby (for example, whether or not the baby will be breast- or bottle fed). Still another class of questions tends to focus upon individual questioner/respondent interaction: for example, does the patient have any anxieties about the hospital stay or her home situation; does the questioner document "learning needs" while in hospital.

Autonomous responses: episiotomies.--Table 6 seems to substantiate the nurses' perception of a racial difference in physiological response to parturition; that native women have fewer episiotomies than non-natives.

The proportions seem to vary inversely by race: 35 per cent of non-native women do not require episiotomy, while 61 per cent of native women give birth without the procedure. It was thought that the tendency for larger native families--hence more deliveries of multiparous women--might account for those figures, so subsequent tests were made of the data, separating primiparous women from multiparous women. Those results are shown in Tables 7 and 8. These tests of independence tend to substantiate

	Episiotomy Performed	Episiotomy Not Performed	Totals
Native	17 (39%)	27 (61%)	44
Non-native	58 (65%)	31 (35%)	89
Totals	75	58	N=133*

*Does not include 2 missing cases and 10 caesarian sections.

Table 6.--Episiotomies Performed--Three-Month Study

	Episiotomy Performed	Episiotomy Not Performed	Totals
Native	8	7	15
Non-native	26	5	31
Totals	34	12	46

χ^2=4.889 df=1 p=.03 N=46

Table 7.--Episiotomies Performed on Primiparous Patients--Three-Month Study

	Episiotomy Performed	Episiotomy Not Performed	Totals
Native	9	20	29
Non-native	32	26	58
Totals	41	46	87

χ^2=4.39 df=1 p .05 N=87

Table 8.--Episiotomies Performed on Multiparous Patients--Three-Month Study

the claim by the nurses that native women require fewer episiotomies, regardless of how many times they have given birth, than non-native women, given the probabilities associated with the χ^2 values obtained.

Patient choices.--Adoption. Another "difference" noted by the nurses was the tendency for "unmarried" native women to put the child up for adoption. In the 12-month study, 36 native women were unmarried mothers, and the two children adopted were from this group. By contrast, five non-native mothers were unmarried, and all of them kept their children. The difference was so slight as to be meaningless, except as one defines the category, "marriage." That, itself, is defined differently in the two populations --common-law marriages being very common in the native population. No inference can be made from the figures in the data; and no inference can be made from the claims above respecting differential definition of terms, except, perhaps, to suggest that the nurses' perceptions are misleading.

Breastfeeding.--The nurses uniformly documented a decline in breastfeeding among native women. Only a longitudinal study could show whether or not the native women actually showed a higher incidence of breastfeeding during some recent period, but the results of the three-month survey, as shown in Table 9, document no difference between

	Breast-Feeding	Bottle Feeding	Total
Native	22	26	48
Non-native	49	45	94
Totals	71	71	142*

*missing observations: 3

χ^2=.503 df=1 p=.48 N=142

Table 9.--Breastfeeding--Three-Month Survey

populations. The 12-month survey (Table 10) shows a probability of .1 associated with a χ^2 value of 2.468. While this does, on the face of it, allow for a greater probability of difference, the probability associated with the measure of independence is at a level not usually considered conclusive in social science. Simple descriptive statistics from the 12-month survey, where

	Breast-Feeding	Bottle Feeding	Total
Native Native	19	41	60
Non-native	27	33	60
Totals	46	74	120

χ^2=2.648 df=1 p=.1 N=120

Table 10.--Breastfeeding--Twelve-Month Survey

racial samples were equal, show that 12 native women and 11 non-native women had attempted at some previous time to breastfeed. Out of that number, one native and three non-natives said that they had "had trouble with it." The numbers are too small to attempt to establish any difference in populations, but results of this study would appear to indicate that there is no real difference established in this area between native and non-native women.

Circumcision.--The nurses noted a tendency among native mothers to reject circumcision, and attribute it to cultural factors. This is an interesting area, because the procedure is ritually performed on a wide variety of cultures, which Textor (1967) documents, in terms of geographic distribution, as centering in dry locales near the equator. Its medical justification has found credibility primarily in North America, where Masters and Johnson (1966) report that the practice is nearly universal in hospital births in the United States, up from an incidence of 40 per cent in the 1950's (Mulcock 1954). It may be losing popularity in the United States (Preston 1970). Preston (1970) reports that the European continent has a comparatively low incidence, ranging from 11 to 30 per cent of the population in Great Britain, to "practically nil" in Sweden. Incidence in infant male circumcision in Australia was approximately 70 per cent in 1965 (Fredman 1969). Canadian figures, from an Ontario

hospital, show a decline from near 60 per cent to around 48 per cent in 1965 (Patel 1966).

Table 11 includes only male children born during the three-month survey, and the level of probability associated with the χ^2 value seems to indicate, because of almost exactly inverse proportions, that native women tend to reject the practice, in comparison to their non-native counterparts. (Because that survey exhausts the population of interest it is probably more nearly indicative of the hospital client population's preferences than the figures reflected in Table 12.)

Table 12, with equal numbers of respondents from each race, is based on the preference expressed before delivery, and shows and even strong tendency for native women to reject infant circumcision (and, incidentally, not so high a proportion of non-native women to request it). Summarily, there seems to be an association, based on race, respecting circumcision, though the degree of association is unobtainable without further calculation (and is not germane to this discussion).

	Circumcised	Not circumcised	Total
Native	6 (27%)	16 (73%)	22
Non-native	41 (76%)	13 (24%)	54
Total	47 (61%)	29 (39%)	77

χ^2=15.89 df=1 p=.001 N=77

Table 11.--Circumcision--Three-Month Survey

	Circumcised	Not circumcised	Total
Native	10	50	60
Non-native	36	24	60
Total	46	74	120

χ^2=23.82 df=1 p .001 N=120

Table 12.--Circumcision--Twelve-Month Survey

Questioner-Respondent interaction.--As these questions from the admissions form relate to perinatal care, perhaps the most important question, given the concern of this thesis, is whether or not any "learning needs" in hospital were perceived. The questioners documented five native women and eight non-native women, from equal numbers of each category, where such a need was noted. (Fifty-five native women's and 52 non-natives' forms were simply not noted in this category.) It appears, given the broad terms of reference which that question might entail, that there is no real difference between nurses' perceptions of the two groups, and that the individually-defined and noted "learning need" is an exception.

Other questions on the form have more to do with specific concerns of the nursing staff for the individual patient. The rationale for the items' being on the questionnaire is that an accounting must be made for

individual differences which are normally considered to be extra-medical considerations. Because there is a differential in the complex of questions posed to each patient or noted on the form, it may be assumed that the individual taking the "nursing history" uses personal and professional judgement (as that term might be understood by Holzner [1968]) in posing and noting the questions. They are therefore treated under the rubric of nurse-client interaction. Although all the questions may be said to relate to that general area in some way, the specific complex of questions addressed below are manifestly more nearly adequately describable under that rubric.

It should be noted that all of the non-native patients spoke English, while six (ten per cent) of the native respondents did not.

Table 13 notes whether or not some anxiety was noted on the patient's part about her hospital stay. Table 14 notes whether or not any anxiety was expressed about the home situation of the patient. The tables show exactly the same figures and configurations, so it must be pointed out that positive responses to the questions did <u>not</u> come from the same respondents.

The remarkable conclusion to be drawn from Tables 13 and 14 is that, while the positive responses--the patients who "have anxieties" about either the hospital or home

	Yes	No	Not Noted	Total
Native	3 (5%)	42 (70%)	15 (25%)	60
Non-native	1 (2%)	0	59 (98%)	60
Totals	4 (3%)	42 (35%)	74 (62%)	N=120

Table 13.--Patient Anxieties About Hospital Stay Noted

	Yes	No	Not Noted	Total
Native	3 (5%)	42 (70%)	15 (25%)	60
Non-native	1 (2%)	0	59 (98%)	60
Totals	4 (3%)	42 (35%)	74 (62%)	N=120

Table 14.--Patient Anxieties About Home Situation Noted

situation--are generally the same for both populations, the response was simply "not noted," almost uniformly, on the non-natives' nursing history forms. The difference must be ascribed to the medical staff worker who completes the history, and it is obvious that a differential in the perception of racial difference is a determining factor in the cell frequencies on Tables 13 and 14.

A somewhat different distribution is seen in Table 15, the question as to whether or not the patient has a reliable baby sitter. While no negative responses were recorded for non-natives, the question was asked more often of native mothers.

	Yes	No	Not Noted	Total
Native	41 (68%)	4 (7%)	15 (25%)	60
Non-native	25 (42%)	0	35 (58%)	60
Totals	66 (47%)	4 (3%)	60 (50%)	N=120

Table 15.--Responses Noted As To Having a Reliable Baby Sitter

In Tables 16 and 17, questions relating to seeing a social worker and the need for baby clothes, there is a repeated pattern: non-natives were not asked such questions as a rule. Once again, staff perception of difference seems to dictate the configuration of the tables.

	Yes	No	Not Noted	Total
Native	8 (13%)	52 (87%)	0	60
Non-native	1 (2%)	0	59 (98%)	60
Totals	9 (7%)	52 (44%)	59 (49%)	N=120

Table 16.--Responses Noted As To Question About Seeing a Social Worker

	Yes	No	Not Noted	Total
Native	20 (33%)	40 (67%)	0	60
Non-native	4 (7%)	0	56 (93%)	60
Totals	24 (19%)	40 (33%)	56 (48%)	N=120

Table 17.--Responses Noted As To Question About A Need For Baby Clothes

Postnatal Education

The only question on the nursing history form which relates specifically to postnatal education is the request for a family visit. The results are shown in Table 18.

It is unclear from the forms just what constitutes a negative response and what is simply not noted. (Ten native respondents were either from remote areas or could avail themselves of other services, and their forms were marked "not applicable"). The noteworthy aspect of the configuration of frequencies in Table 18 is that of the positive responses of the non-native population. It is possible that, just as they appear to take more advantage of institutional antenatal services, non-native mothers refer, more than native mothers, to the same complex of health-service-oriented institutions for postnatal care and education.

	Yes	Negative, or Not Noted	Total
Native	11 (22%)	39 (78%)	50
Non-native	35 (58%)	25 (42%)	60
Totals	46 (42%)	64 (58%)	N=110

Table 18.--Response to Request For Family Visit

CHAPTER V

IMPLICATIONS

This chapter is an attempt to generalize the results of the exploratory study, without respect to the divisions so far employed: the interviews and the data surveys; the distinctions between ante-, peri-, and post-natal care are synthesized in a discussion of the educational needs which the study implies.

It may be stated at the outset that several population differences were implied in the data. There does seem to be a differential in response to health care based on a native/non-native difference. There also seems to be a differential based on treatment, the origin of which is thought to be in the staff's definition of that perceived differential.

It is the reconciliation of these things that this chapter addresses. There should be no implication herein that Cohen's (1971) "education"--stereotyped, formalized behaviour--be embraced as a mechanism for societal change. The values and practices of any defined subgroup of the population are not seen as manipulable through a process defined as "education."

It is, rather, the "body of knowledge" that the health care professions incorporate, and by which they define themselves, which is addressed here.

How Much Medical Knowledge Does the Patient Need and To What End?

The survey and interviews showed a curious paradox. In the first place, the antenatal classes were established to serve a "priority" clientele, due to a stated need. The classes were not, for the most part, taken advantage of. The public health nurses' preference for a "one-to-one" relationship in patient education; and their concommitant maintenance that anatomical and physiological knowledge was not important; say a great deal about this paradox.

Despite this specifically defined need, the native patient was stereotyped as a "good" patient.

Given the simultaneous definition of the native, by the knowledge-oriented work community, as "good patient" (by implication, perhaps, better than non-natives) and as "patient with specifically-defined learning needs" (by implication, perhaps, greater than non-natives) the question arises: how does the work community justify the maintenance of at-least-in-part conflicting definitions?

One might initially consider the service's changing clientele, from uniformly native to a majority of non-natives. It follows from Holzner's (1968:127) definition of the work community, "where knowledge itself becomes the

focus, rather than the mere tool of work" and where "power strategies" are used to create "simplified and stylized representations of behavior patterns" to create "role images," that a clientele which the service seeks to retain as a priority clientele be differentially defined as "in need." Thus, learning needs specific to the native population are necessarily defined, and the role image attempted is one that purports to meet such needs. The differential by ethnicity of questions asked on the nursing history form is artifactual of such role management.

The actual differences in response to treatment or to the utilization of services is documentary of the layman's failing, to some extent, to validate the "reality construct" of the work community, as it is evidenced in the creation of the role image.

The response on the part of the work community is thus, implicitly, to posit a kind of "cultural knowledge" that makes the native patient a good one.

The paradox is necessarily maintained, in order, on the one hand, to create the role image; and on the other, to explain why the client population does not entirely validate it.

Native reaction to the treatment.--It is evident that the native population is not as amenable as non-natives to acceptance of those defined educational needs enunciated by the medical service establishment, nor to

acceptance of the educational "delivery system" the establishment has provided. For example, the documentation of nurses' concern over neglected doctors' visits, the perception of the reduction in incidence of breast-feeding, are educational areas where the system is perceived to have failed. (There is little concern for the difference in circumcisions: that difference is evidently perceived as innocuous, though the nurses may certainly know the "medical" justification for the "routine" procedure, and it is probably becoming more of an elective procedure than heretofore, at any rate.)

The implications are, however, that some educational deficiency can be defined in the native population. The educational goal in mind may not have as much to do with the improvement of medical care, however, as with the layman's validation of specialized knowledge, as is suggested in the preceding section.

Educational Needs of the Work Community

Cultural knowledge.--The tacit assumption of different values is clearly an ill-defined perspective from which to work. It is fairly evident that medical service personnel have no clearly-defined idea of the components of that knowledge, interpreting "shyness" and "stoicism", for example, as self-assurance and composure. Nor do the nurses seem to have a clearly-defined notion of "culture."

Cultural differences.--It is suggested that as medical personnel approach the definition of cultural difference, it is a heavily value-laden definition. From the nature of questions uniformly asked of native women, and rarely of non-native women, there is an apparent definition of status-differential associated with racial or cultural difference.

The hierarchy.--If nurses wish to validate their own expertise with the layman, they may well need to "educate" the layman as to the nature of the institution in which they operate. Services are provided in a social setting in which there is a definite hierarchy. That hierarchy dictates the specific axes upon which specific personnel have access to patients, and vice-versa. Staff behaviour is thus dictated in part by this social configuration, and that may or may not be congruent with the patient's own perception of (a) needs, and (b) resources. It is not out of the question to suggest that patient familiarization with this hierarchy and its unique structure might potentiate greater access to medical services.

Summary

The educational needs implied by the study relate to those of the "knowledge-oriented work community." This means that the body of knowledge by which this specific community is defined must be enlarged to include other

than "medical" information, because, lacking it, the "medical" knowledge may (1) be ineffective; and (2) may not be validated by the clients. The specific need is for knowledge of individual and cultural differences and for training in cross-cultural and intercultural communications, making explicit the "cultural knowledge," and acknowledging, in Holzner's terms, the natives' constructs of reality. A necessary concommitant is the acknowledgement, in the same terms and at the same level of objective analysis, of the reality construct of the work community, not on "normative grounds [with] which to defend the superiority of any particular perspective such as that of science," but instead, the social conditions that make "medical knowledge" into "fact" (Holzner 1968:14-15).

An obvious need is for more medical personnel from the native population to be trained as medical personnel.

Implications for Further Research

This study is exploratory. The primary implication for further research addresses the areas of generalizability and inference. Do population parameters, based on random samples from a more widely defined population maintain the differences between natives and non-natives found in this study. The second area is in the definition of more and better-defined variables: for example, do age, locality, formal educational level, political activism,

or "traditionalism" influence response to the medical establishment and the services it provides?

Another area of research which the present findings suggest is in the domain of the cultural knowledge of the clients. We have very little idea, even, of how the native women categorize childbirth, and the traits, values and technologies they attach to it. We have very little idea of the variability within the native population.

The kinds of cross-cultural studies in native categories carried out in the field of ethnographic semantics in anthropology would instruct both the academic and professional-practical communities.

It is obvious that the population of interest in such studies might be either the native community, or native communities; or the knowledge-oriented work community itself.

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APPENDIX A

NURSING HISTORY FORM

NURSING HISTORY--MATERNITY

G____P____A____ Ages of Children at home_____

Blood Group____EDC____Prenatal Classes____Where_____

Do you wish the father of the baby in the Delivery Room?__

Will you wish visitors after delivery?_____

Past Illnesses or Chronic Conditions:_____

Allergies_____

Appetite_____Special Diet_____

Bowel Habits_____Laxative_____Voiding_____

Hearing_____Sight_____Prosthesis_____

Languages Spoken:_____

Hospitalized Before?_____Where?_____

When did you visit your doctor last?_____

Do you need baby clothes?_____

Anxieties re hospital_____

situation at home_____

Do you have a reliable babysitter?_____

If unmarried, are keeping the baby?_____

Social Worker_____

Special treatments while in hospital_____

Breast feeding_____Have you done so before?_____

Did you have any problems breast feeding?_____

Do you wish a family visit?_____

Do you wish your baby circumcised?_____

Learning needs in hospital:_____

APPENDIX B

INTERVIEWS

Interview Number One

Respondent: Supervisor, Outpatient Department
Location: Hospital

How many obstetrical clinics are held in a week?
Three, right here in the Outpatient Department.

When native women come to the obstetrical clinics do they have a choice who they want to see?
Yes, they usually know who the baby doctors are and they tell the desk clerk, who is Metis and speaks Cree fluently, who they want to see; but often they do ask me. A great number of appointments are made over the phone.

How often are mothers seen during pregnancy?
The rule is the same as for other patients: once a month, and, late in pregnancy, every two weeks.

Are native mothers always seen by the doctors of their choice?
One of the doctors always sees his patients; he does not delegate work. The two other specialists often have their obstetrical residents and medical students see the patients but one doctor is in the clinic more often than the other.

Are other patients going through the obstetrical clinic as well as natives?
Very few. Most of the other patients go to the doctor's offices; they are definitely private patients.

Do native mothers return for their six-weeks post-natal check-up, and do they bring the baby?
Many patients do not come back after they are delivered.

Why?
Many have transportation problems or no babysitters. Also, obstetrical and baby clinics do not coincide, and that means that the patients would have to return with the baby a second time. And many native women do hold a job and cannot take time off whenever they want. In fact, I assume that native women often return back to work before the customary period of six weeks post-natal time has elapsed.

Do native women at that time ask about birth control methods?
Not only at that time, but very frequently over the phone and during clinic visits. For many native women it is not necessary for the staff to suggest birth control methods--they want it themselves.

What do you think is the reason for the hospital to have suddenly so many fewer native maternity patients than a few years ago?
The younger native woman is much more independent, but still they seem to seek a one-to-one relationship, and the influx of so many learners into this hospital does not always guarantee this relationship in medical care: hence, they go to smaller places.

What type of native mother do you think comes to this hospital?
That is difficult to determine, but it appears as if the woman who is dependent on social affiliation with her own people and sees this hospital as a social meeting place of native peoples. Also, many people have had some form of association with this hospital, many from infancy, and they are familiar with many things, including knowing the other health care workers. But the newer class of native person chooses according to what is more convenient and what she prefers.

What do you consider "the newer class" to be?
Verbal, independent and able to choose without prompting; also, many work, especially the women.

How do you address the native women?
I always call native women by Christian names, and so does the ward clerk, but the women do the same to us. Sometimes we have known each other for years, and it comes quite naturally.

What about the rest of the nurses, how do they address the patient?
Some of the staff call patients by Christian names--that is, the ones they know well--but then the patient may do the same. But as a general rule, they are not addressed by their Christian names.

Do you call native male patients by their Christian names?
No, most certainly not, unless they are young boys or I know the man really well.

Why not?
A man is a man, and perhaps for the native male, the title "Mister" or "Sir" shows our respect. But women are our own sex, and we seem to be able to communicate better by dropping formality.

Interview Number Two

Respondent: Physiotherapist
Location: Hospital

What form of exercises do you see as important in the teaching of obstetrical cases?
Prenatal exercises are given to all patients who attend the antenatal classes. We consider these exercises a great help to a woman in labour. We teach the following. (a) Different breathing levels for the three stages of labour; (b) abdominal breathing, and when the strength of contractions increase, chest breathing. This is recommended for the first stage, when the dilation of the cervix takes place; (c) breath control for exulsive movements in the second and third stage of labour; (d) panting exercises for the actual delivery of the baby in the second stage of labour.

Do all patients have exercises?
No. Prenatal exercises are only taught to those who attend the classes. But all patients do receive postnatal exercises while in hospital, unless the condition is such that exercises are contraindicated.

What kind of exercises do you teach?
We explain, demonstrate and supervise such exercises as will aid in regaining the muscle tone of the abdominal wall and the pelvic floor. Some women are very anxious to regain their figure. Also we give patients a list of exercises which they can do at home on their own if they so desire.

How do native mothers respond to the exercises while in hospital, and do you think they do them when at home?
Native mothers do the exercises in hospital as we give them. Whether or not they do them at home is a question which cannot be answered other than by speculation. Maybe, maybe not.

Do you think other mothers do postnatal exercises after discharge?
This is more in keeping with our culture, which stresses good appearance. Yes, these exercises are done.

Interview Number Three

Respondent: A public health nurse
Location: The interviewer's home

Note that material shown in brackets ([. . .]) is descriptive of the respondent's response, and not quoted directly.

How many reservations do you serve?
[The respondent describes a number of reserves northwest of the metropolitan area, between 200 and 350 miles away.]

What health care teaching do you provide for the pregnant women?
I play it by ear, because patients do not come to the clinics and I do not believe they will in the future, simply because they do not see the need for it. Hence, my aim is to get them to the doctor, even if I have to drive them there and back. To me, the state of the hemoglobin and the general health of the mother is much more important than her understanding of what actually goes on. That would be the ideal situation, and we are not liable to get such a situation yet, if ever. Also, it seems logical to assume that native women have their own idea of what pregnancy is and what happens. And that may not coincide with our scientific version, but in their mind it is valid, and therefore needs to be respected.

What do you teach?
I try to have a talk with the individual woman, but I never tell anyone what they must do. To me, diet is an important issue; the rest can be done by the doctor. The current literature which we have and use is good, and the present-day Indian mothers are much more educated than they were 15 years ago; hence, they seem to be much more selective and verbal in what they want and in what they are going to do. I have a distinct feeling that some natives have had enough of being taught, and told what to do. Just consider the number of organizations which try and influence them. If the native people would attend all the meetings--for example, housing, education, environmental, health, and so forth--there would hardly be any time for the family, because someone else needs time, and each outside group tries to influence these people (as to) how things should be done. Perhaps it is about time to ask how, what, and who should do things for natives. We might be surprised to hear the answer.

Why do you think patients do not come to organized classes on the reservation?
For the same reason I have mentioned before. In addition,

there is the problem of transportation and distance, weather conditions, and the family at home.

Do you think most mothers come [to the urban area] to have their baby?
Why should they? Mothers are going to the nearest hospital. There they have their individual doctor and they get to know who delivers them.

To what hospitals do the patients go for delivery?
[The respondent identifies three hospitals in the area in which she serves.]

How are you received by native mothers when you visit them in their homes?
Quite well, I think. I am careful and make quite sure to have a valid reason to enter their homes and I attempt to respect their privacy.

How many mothers from the reservation do you think are breastfeeding?
The women who breastfeed are the exception rather than the rule. It just is not fashionable at present to put the baby to the breast.

Have you heard of any native midwives practicing the art?
No, indeed not. Modern medicine has achieved that much status so that women feel ready to be delivered by health care workers.

Bottle feeding is more expensive than breastfeeding. How can this economic and health factor be stressed?
It has been stressed, also the point of needing extra time for bottle sterilizing, but it has not made the required impact. Somehow, native women are leading a quiet revolt, and perhaps in the past we contributed to this fact, especially during the infectious-disease periods, such as tuberculosis, when it was necessary to separate mothers and babies, and we stressed the fact that babies do well on bottle feeding.

Why do you think native mothers are not breastfeeding?
Well, I think there may be a number of reasons, but most of them are speculations. Bottle feeding infants can be done by anyone, and the mother does not have to be there. Also, the baby can be propped--and very often is--and that too leaves the mother free. Maybe it is a form of emancipation not to breastfeed.

How do you address native women?
Just as I address every other patient--"Mrs." or "Miss"; but the 15 to 16-year olds I call by their Christian

names, don't you know. But I consider it an insult not to call them by the title which is their due.

How do native women address you?
They cannot pronounce my name, therefore they address me by my title, "nurse".

Why do you think native mothers do not have their baby boys circumcised?
Well, only a few cultures have circumcision. West Europeans, for example, do not have it. And North America has had circumcision imported, and the reason for it is purely medical evidence that circumcision is a good thing. But why should the Indian adopt it? It is not part of their culture and medical practice.

Interview Number Four

Respondents: Two public health nurses
Location: Hospital

Note that material shown in brackets ([. . .]) is descriptive of the respondents' response, and not quoted directly. Responses in this interview may have come from either of the public health nurses, with the other expressing agreement.

How many reservations do you serve?
We have four Indian reserves in the vicinity of [the urban area] and [a remote camp about 150 miles west of the urban area].

What health care teaching do you provide for the pregant woman?
Teaching is done on an individual basis. In our experience classroom teaching and talking to a group, so far, has not been very successful. We believe the individual approach works better, and the patients simply won't come out to classes--therefore, we go to their homes.

What do you teach?
We give the same classes that are given in [the urban centre], but it is a summarized version, and teaching is on a one-to-one basis. Prenatal visits are made by us once a month, but we stress at that time that our visits do not take the place of a doctor's prenatal visit, although we measure blood pressure and take urine samples. The teaching is done in a very informal manner and has the form of a dialogue. We certainly do not tell patients how much proteins, carbohydrates and minerals to eat. However, we try to find out what mothers think they ought to eat, and after that we tell them what foods build the body of a baby. Also, we very much stress the fact that native foods are just as nutritious as other foods, and just as good for the baby and mother. Generally speaking, we are very selective in what we teach to the individual and we make an attempt to meet individual needs.

Why do you think patients do not come to organized classes on the reservation?
We believe that native people do not like to sit down in groups and be talked to by one person. This form of teaching seems to be too formal. Also, there is the problem of getting to the meeting place: distances are often great, especially for pregnant women. And some native women simply do not see the need for prenatal classes. After all, women had babies from all eternity.

Do you think most mothers come [to the urban centre] to have their baby?
Oh no. In the last few--perhaps five--years, things have changed drastically, and it seems that very few patients go to [the urban centre] for care. Most patients have their babies in smaller hospitals, and there they get to know the medical and nursing staff. Also, the family is not too far away. But in [the remote camp] pregnant women are delivered by local native midwives. These midwives deliver all babies except primigravidas; these go to the nearest hospitals. The whole issue is an arrangement between us and the native people.

To what hospitals do the patients go for delivery?
[The respondents identify six hospitals in the area they serve.] We do a lot of liaison work with these hospitals and the midwives [at the remote camp]. One could call it "interpreting", and again we attempt to have a dialogue with the hospital staff in which we try and put forward the needs of the patients as we encounter them.

How are you received by native mothers when you visit them in their homes?
Very well. The exception is the women who refuse to receive anyone else from any agency.

How many mothers from the reservations do you think are breastfeeding?
Very few. Most native mothers bottle feed. However, the women [at the remote camp] are breastfeeding almost 100%, and do so very successfully.

Have you any evidence that the midwives [at the remote camp] have encountered any difficulties in caring for the patients?
No, we know of none. The first baby is always delivered in hospital; hence, if the women have been successful once and all goes well, the second delivery should go well and without complications. Whether or not there were, or are any complications--that is, complications that are classified as such by medical standards; for example post-partum hemorrhage; and cannot be detected by a lay person--that we do not know. Nor do we know if there are any vaginal or perineal tears. But the patients and infants always appear well when we see them.

Bottle feeding is more expensive than breastfeeding. How can this economic and health factor be stressed?
In bottlefeeding the hospital in [the urban centre] is actually the factor which causes the biggest difficulties for the patients. The infant formula used by the hospital is balanced, easily digestable and pre-packaged--but also

very expensive. Many mothers cannot keep up the expense, and must go to a cheaper formula. This means that they have to change and learn how to prepare the new formula, something which was not demonstrated in the hospital because their formula is ready to go. But most important is the fact that it changes the self-perception of the mothers, because they are inclined to feel that the formula which the hospital provided is the best, and it is not good to change: therefore, they are not "good mothers."

Why do you think native mothers are not breastfeeding?
That is difficult to say. But we believe that many native mothers feel it is not modern. Maybe, some of what has been done in our society has finally caught up with them. Although we explain that sterilizing bottles and nipples is much more time-consuming than putting the baby on the breast, bottle feeding seems to have a different status that caught up with native mothers after white society began attempting to return to breastfeeding, because we recognize it as the better method.

How do you address native women?
Usually by their Christian names.

How do native women address you?
Christian names are a mutual affair--sometimes they call us "nurse" or "Mrs.", but that depends on who it is.

Why do you think native mothers do not have their baby boys circumcised?
That behaviour is not in their culture, and they seem to see no need for it. After all, their men have done well without circumcision. We do not stress this point of infant care at all, but may mention it casually.

Interview (Series) Number Five

Respondents: 12 of the 16 registered nurses on the maternity unit in the study hospital
Location: At the hospital

Note that each interview was conducted invidually, and the following representation of the responses is a synopsis of statements made in interviews. The number (out of 12) of respondents who agreed with a specific statement is shown, after the statement, in brackets. (Total responses may thus exceed 12, reflecting multiple responses on the part of some respondents.) Four nurses, newly assigned to the unit, declined to answer the questions, citing lack of experience and information as their reasons. Bracketed material ([. . .]) in the text represents a description of a response, and is not a synopsis or a direction quotation.

Do most native mothers breastfeed?
The occasional mother does breastfeed. [11]
Breastfeeding among native women is not the fashion. [1]

Why do you think native mothers do not breastfeed?
Mothers perhaps have a greater freedom when bottle-feeding. [5]
Many mothers are going to work, therefore breastfeeding interferes. [6]
The lifestyle among natives is changing, and they, too, are becoming modern. [7]
Breastfeeding may be a reflection of their past: perhaps there is a deeper reason for wanting to change. [2]
It is not convenient; maybe they want to try alternatives. [3]

How do native mothers compare to others during labour?
They are wonderful and take childbirth as a natural event. [10]
They do extremely well. [1]
They never seem to lose their heads. [11]
They do very well, but if a native woman becomes hysterical it is every bit as good as other patients' hysteria. [1]

How do native mothers compare to others in knowledge about pregnancy, delivery and postnatal care?
That depends on where they come from: city girls know as much as do mothers from our society. [4]
These patients get by very comfortably, and hardly ever complain. [8]
They must have managed well in the past, and for native women it is important to have a baby. [9]
Native patients must have the knowledge of their own. [6]

What do native mothers know about episiotomies?
Most of them know that it helps to make room for the baby's birth. [8]
They refer to episiotomies as "stitches", something which is just done by doctors. [4]
What they think is really hard to know, and all statements must be considered speculation. [1]

Have you ever found a native mother who knows nothing or little about childbirth?
No, not one: they behave much better than other patients during labour and delivery, and must have their own information. [11]
Maybe the very young are not so secure, but they too do very well in labour and afterwards. [1]

How do native mothers handle their babies after delivery?
Native women are used to handling babies. [12]
They are very natural with them. [11]
They have their own way of handling babies, but do so very securely. [6]

Why do some native mothers give up their babies for adoption?
Because some of them lack the family support, especially if they live in the city. [8]
Native women are now earning their living and holding jobs, but that may still not be sufficient to raise a child alone. [8]
Many are not married in our conventional manner, and may lack male support, and therefore cannot handle the situation. [3]
Native women have fewer, if any, abortions. [4]

Why do you think native mothers do not have their baby boys circumcised?
It is not part of their way of life. [4]
Their husbands may not be circumcised, and therefore there is no reason why the child should be. [8]

What reply do you get when you ask mothers whether or not they will have their baby boys circumcised?
We have to be very careful about that and explain it very well, because the answer is always "yes" when the question is put forward, but when the procedure is explained, the rejections are very positive. [12]

Why is it that a native mother occasionally will permit her baby boy to be circumcised?
Do not know. [9]
Perhaps the father of the child wants it. [2]
Maybe the mother has experienced difficulties with foreskin infection in the care of another infant. [1]

What do you think is the reason for this hospital to have suddenly so fewer native maternity patients than a few years ago?
Patients have a choice and go where they like. [12]
Patients are much more inclined to stay nearer their own homes. [12]
The modern natives are much more verbal and can say what they want, and so choose their own doctor and hospital.[8]
The younger generation is intelligent and much more independent, especially the working mother. [4]

What type of native mother do you think comes to this hospital?
Those who live nearby or have had previous experience in this hospital. [8]
Many patients know some members of the nursing and medical staffs, and therefore may feel more secure. [4]
It seems that some patients regard this hospital as a social meeting place for their own people. [10]

How do you address native women?
"Mrs." if they are married. [12]

You could call the unwed mother "Mrs." as is done in other hospitals. Why don't you?
If we do call them "Mrs." they usually correct us, and when we ask what we should call them, the answer is usually the Christian name. [12]

What do patients call you?
Patients get to know us from our name tags. Those who know us well may call a particular nurse by her Christian name, or address her as "nurse". [12]

Do you call the native male by Christian name when they visit?
No. [12]

Why do you think we have not been successful in getting native mothers to antenatal classes?
Perhaps they cannot come when the classes are held. [6]
They may not see the reason; after all, women had babies without having classes for a long time. [8]

Are native mothers when in hospital delivered and seen by the doctor of their choice?
One doctor always delivers every one of his patients, unless he is on vacation or ill. The second doctor delivers some, but the resident and the medical students deliver many, as part of their obstetrical experience. The third doctor leaves much of his work to the resident and medical student; he serves as a resource person. [12]

Interview Number Six

Respondent: A registered nurse, who is also a registered Indian by birth
Location: At the hospital

Note that material shown in brackets ([. . .]) is descriptive of the respondent's response, and not quoted directly.

Do most native mothers breastfeed?
No

Why do you think native mothers do not breastfeed?
That is a very complex issue and really difficult to analyse; also, at present, much-discussed on Indian reserves. A short while ago an Indian male discussed this subject on the radio. He believed that much of the disruption on the reserves is due to the fact that infants do not have the closeness of their mothers', and women are occupied with something else. In addition, during the periods of long hospitalization for tuberculosis, mothers and babies were separated, and such mothers were convinced by health care workers that bottle feeding was a good thing, and the thing done by society at large. That should be considered a very profound influence.

How do native mothers compare to others during labour?
Well, native women are brought up to be subservient; that is, their role prescribes that they put up with hardship, misery and suffering. Even if they are miserable in labour they would not tell or complain, because it is not right to do so. A city nurse usually believes that native women have a very much higher pain tolerance than other patients, therefore they are able to take everything very casually. But in fact, it is cultural conditioning which stipulates behaviour.

How do native mothers compare to others in knowledge about pregnancy, delivery and postnatal care?
I believe the native pregnant women know what happens; they see and feel changes, but they do not know why these things happen in terms of basic anatomy and physiology. Perhaps the girl living in the city has the opportunity of gaining greater understanding, but it is questionable if the same applies to the women from the reserves. Contrary to what is often thought in white society, today's native girls are not taught by their parents about sex, childbirth and menstruation. These things are simply not discussed as a rule. When menstruation happens girls are informed that this is the lot of women, and that is it. [An example is given about how a woman is told to take care of herself when first menstruation occurs, but that "never was it

mentioned that puberty also had other implications.] For native women the role acceptance of being a woman definitely determines behaviour. In their silence during labour, this role is acted out, and health care workers refer to the native woman as a good patient. The silence often expresses a feeling of inferiority. That is, I know that native women feel definitely at a disadvantage, and therefore act passively and accept what is offered. The majority of native women are aware of the true reality of life, and in a hospital situation seem to see no point in trying to say that they cannot do many things which are advocated as "right" in the dominant society. Native women have a "cultural lag" in some aspects, and their subservient role is reinforced by the Indian male, who insists on, and demonstrates dominance. Most natives are quite shy, and this is an added disadvantage in a hospital setting.

What do native mothers know about episiotomies?
Most of the time they believe that stitches are "something done by the doctor"--therefore it is accepted. The younger girl, however, is more readily inclined to ask and perhaps knows that the cut helps to increase the pelvic outlet. But most do not understand that it is really for the prevention of perineal tears.

Did you find a native mother, ever, who knows nothing or little about childbirth?
Yes, especially among the very young. These girls are often very frightened, but conceal it extremely well by an impassive appearance.

How do native mothers handle their babies after delivery?
They manipulate infants very well, because most of them are used to children. But they have also adopted rather undesirable habits. With bottle feeding, it often means that the baby is propped rather than handled. Propping is very common after discharge from hospital.

Why do some native mothers give up their babies for adoption?
This is a new social issue, and most of the adoptions are taking place because of this changed social situation. It is difficult to pinpoint the reasons, but the main thing is probably the inability to support the infant.

Why do you think native mothers do not have their baby boys circumcised?
It's not in the culture. No need is apparent.

What reply do you get when you ask mothers whether or not they will have their baby boys circumcised?
I explain the procedure, and they do not feel they need it.

Why is it that a native mother occasionally will permit her baby boy to be circumcised?
These women have their own specific reasons, but I suspect that it is an association with a man who is circumcised and who wishes the same for the baby.

What do you think is the reason for this hospital to have suddenly so much fewer native maternity patients than a few years ago?
Patients no longer have to go or need to be shipped to specific hospitals, and the younger generation is testing alternatives.

What type of native mother do you think comes to this hospital?
I think convenience is the main reason.

How do you address native mothers?
I call them all by their Christian names, and they can call me--and readily do so--by mine.

Do you call native males by their Christian names when they visit?
Only if I know them personally. On the maternity unit, contact with fathers is on a very limited basis.

Why do you think we have not been successful in getting native mothers to antenatal classes?
That's difficult to say. Maybe they do not feel the need for it at present, and perhaps when they are more at ease, comfortable and secure, that service may be made use of, too.

Are native mothers, when in hospital, delivered and seen by the doctor of their choice?
One doctor is always there for the delivery and general care of the patient. The second doctor is there most of the time, but his resident or medical student may deliver the patient, as is often the case in teaching hospitals. The third one hardly ever delivers native mothers; he is not always there for his private patients either. Native women, more so than others, can expect to be delivered by learners; at least that seems to be the case, judging from observations.